

**Mind in Brighton & Hove  
West Sussex Advocacy Services**

**ANNUAL REPORT**  
(for period 01 April 2007 – 31 March 2008)

**ADVOCACY SERVICES :**

**Mid Downs Advocacy Service**

**Mid Sussex Advocacy Service**

**Chichester & Bognor Advocacy Service**

**Worthing, Adur, Arun & Chancetonbury Advocacy Service**

**ADVOCATE :**

**Bill Turner**

**Mo Davies**

**Sandra Trebble/Claire Allwright**

**Malcolm Bateup**

**General Overview**

- This report presents a composite with input from all advocates. In addition to the staff changes outlined in the 6 monthly report, there have been other staff changes since October 2007. Trevor Walshe who was job sharing in Crawley and Horsham left and Bill Turner returned to a full time post covering this patch. The advocacy services continue to be very busy with most advocates working to capacity and dealing with extremely complex issues. The figures for Mid-Sussex are lower than would be expected but this was due to a protracted period of sickness during October – December 2007.
- Other than the bread and butter benefits and housing issues, we also dealt with legal issues which continued to feature highly in the WAHMS advocacy caseload. Advocates will help people challenge both criminal proceedings through mitigating circumstances regarding their mental health, and family court issues regarding care proceedings. We are often successful in reducing or overturning serious legal decisions which effect people's lives.
- We also re-secured a small amount of funding from Sussex Partnership Trust in March 2008 to continue to run the Patient's Council at both acute units in the North of the county. We currently have 4 volunteers providing this service on a monthly basis.
- Our successful advocacy service continues to attract spot purchased pieces of work. We are currently commissioned by West Sussex Supporting People to provide advocacy through a decommissioning process of 2 small residential units in Bognor Regis.
- From a management point of view we are hoping to expand the advocacy service to include working with older people as there is a serious gap in advocacy provision for them which is discriminatory.
- We are also closely monitoring the development of the Independent Mental Health Advocacy (IMHA) role and would hope to pilot a scheme if any become available. We will of course be tendering for and proposed IMHA service in the future.
- Following on from the review process with the Mental Health Commissioning Team (MHCT) we have taken steps to separate out the management of our advocacy services from the management of the alternative day services based in Horsham. This is to ensure that there is no conflict of interests around the independence of advocacy services. We plan to recruit a Team leader for advocacy services in May 2008 and I will retain over all service management of West Sussex services.
- We are applying for accreditation to the new National Standards for Advocacy which are currently being piloted by Action 4 Advocacy. This is a quality mark which has to be reviewed annually.
- MHCT awarded us an additional £35K at the end of this financial year for 2008-2009 in order to build capacity and concentrate a dedicated advocacy resource onto those service users who are moving out of residential care into more independent living.

Kate Webb June 2008

**Equal Opportunities Information**

- There is no advocacy service for people over 65; there are a number of health and social care

settings for older people with mental health problems who have no access to an advocate. The nature of advocacy in this field has to be proactive, our service does respond to every referral from older people services.

- There appears to be a low uptake of advocacy related issues from the Asian community in Crawley; very few referrals are forthcoming from this sometimes marginalised, difficult to engage with group of people. A thorough piece of research was undertaken in 2002 by Mind to explore reasons as to why this appears to be the case, but hitherto there is no real evidence that anything significant has happened in relation to advocacy enquiries from this client group.
- Clients or potential clients in residential homes are not easy to access. There are many homes in the Bognor area with residents brought in from outside the area. Some homes are fine with advocates being involved and are reasonably welcoming but many are difficult to access. I have attempted to raise awareness of advocacy in these homes over the years but do not feel I have been very successful.
- I understand that there will soon be a psychiatrist who will specialise in autistic spectrum disorders which is certainly needed as this group of service users struggle to get their complex needs properly heard and addressed.
- There are still major gaps in service across Sussex for LGBT clients. Last year we voiced this at the LPIG but due to the merger of trusts, funding constraints and judging other priorities to be higher no funding or support provision was offered. There are several people with LGBT issues in the Worthing and Littlehampton area that all have to travel to Brighton (to Mind in Brighton & Hove's MindOut service) just to receive support incurring transport costs for attending a specialist LGBT service.
- I try to regularly check supplies of leaflets at CMHTs, wards, custody block, GPs surgeries etc. Consumer Group members often help by taking supplies of leaflets to their surgeries and services they attend and I visit community services when I can (or when invited) to talk to service users and tell them about advocacy.
- Networking within Mid Sussex is an ongoing process as there is a lack of resources and clients are unaware of the services on offer. Leaflet and poster distribution in the community as well as CMHC for the advocacy service paying particular attention to the rural areas GP practices, local council/housing offices, library etc.
- We no longer have advocacy services for the substance misuse/alcohol clients in Mid Sussex but will engage with clients who are also under the CMHC.
- Legal mental health work has increased enormously. Managers and MHRT tend to request referral to an advocate more frequently, particularly when the client is not represented by a solicitor. I now have a good working relationship with the MH Administrator based at Centurion and she has begun to hand out advocacy leaflets to all patients held under MH Act which has increased referrals.
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### **Difficult Issues**

- Crown Court, vulnerable client looking at jail sentence, would not have survived in that environment, achieved suspended sentence with our intervention and representation at court.
- One of the other key and complex issues that comes up time and time again is highlighted in my case study; Incapacity Benefit stopped following the DWP medical assessment. This is driven by government policy to get people off benefit and back to work. Mind could take this issue with the DWP and request funding in order to support and assist people with mental health problems at these medicals.
- Mind could make representation to the Crown Court system re not knowing if case is going to be heard until the evening before. This on several occasions has caused distress to clients and messed up the advocate's diary
- Two, not necessarily 'difficult' but more protracted cases involved long drawn out correspondence and telephone discussions around two individuals' application for British citizenship. As has just been mentioned many times in the national media – liaising with the Home Office can be an extremely frustrating and time-consuming experience, for everyone involved. Patience is definitely a virtue when dealing with this Government department!
- Capacity issues – a learning experience for all but resolved in the end. Client originally labelled as completely incapable but after request to reassess this was changed.
- Allegations re abuse in residential care – ongoing but looking more hopeful now as multi agencies are involved.

- One of my clients needed a high level of engagement in order to help him choose and taken action on a range of support that had been suggested by his OT but nobody seemed to have taken time to talk to him about this (obviously quite a challenging and time loaded task). He also needed support as he struggled to overcome barriers caused by his diagnosis of Aspergers Syndrome to taking up the suggestions. I spent some considerable time talking through each option and helping him make informed choices, as well as communicating with other workers to obtain support for the client around specific barriers. During a professionals meeting I did challenge the team about who should have followed through on proposals in the Care Plan.
- Two clients at the Bedale both seem to have a Care Plan only in the form of a letter with important details left out e.g. for both clients there was a sense of no-one taking the care-coordinator responsibility, and things had ground to a halt.
- We have become aware that several clients in the Chichester and Bognor area have not received mail which was supposed to have been sent out from the CMHT's regarding appointment times and/or client issues not being followed up effectively. This resulted in people not seeing care coordinators etc when needed.
- In one court case I feel that I stopped four children being adopted when I was initially involved. I attended a social work meeting with the client who was given adoption papers to sign. This was a very vulnerable client with a personality disorder and drug/alcohol issues. It was clear that the client's view had not previously been taken into account. I was able to liaise with the CMHT and Drug & Alcohol team to gain access to services after attending initial triage assessments and more comprehensive assessments at Options and her wish for Rehab. This client is now undergoing four months funded rehab.
- I dealt with a very difficult and complex dual diagnosis complaint in which the client did not want to go over the same upsetting summary of their life to ICAS. By building up trust with the client I arrange a meeting with myself and ICAS and negotiated on behalf of the client to the CMHT and Drug & Alcohol team. In this kind of situation advocacy plays a vital role and is usually caught in the middle challenging professional decisions on behalf of the client as well as supporting clients with complex enduring mental health problems, so it needs a sensitive and assertive approach all at the same time to diffuse difficult discussion but at the same ensuring the client is being heard.
- Due to staff sickness the service in Mid Sussex was limited and this is reflected in the poor stat figures for this area and shows a limited amount of contact with clients although other workers did work with clients from Mid Sussex and therefore the figures are perhaps not as accurate.
- Due to the long and drawn out amalgamation of the CMHCs this has been over 6 months the clients attendance at Linwood has considerably dropped only attending appointments with their Care team. Most of the groups have been put on hold so clients have not used the advocacy service as before. Most of the work with clients from Day Services would be when they would pop into the office as they were coming to their groups. Some of the issues presented to the advocacy services are now being taken to their care co-ordinators who in turn refer to the community support workers who often work with clients around benefits/housing taking away some of the work that in the past would be referred to the advocacy service.
- Overall it seems this year that the number of clients in Mid Sussex are not as high as other areas and the numbers of active and one-office referrals fluctuate. We have worked with some very complex issues on behalf of the clients and the issues presented have been varied and challenging with not many negative outcomes.

### **Evidence of Service User Involvement**

- I continue to facilitate the Consumer Group (covering Bognor and Chichester patch) monthly and we have more than 30 members on the circulation list. Some attend only once or twice a year but a small core group come to nearly all meetings. The group is now planning to relaunch and become more active. Have renamed to Mental Health Forum (for service users). Members are looking at funding options themselves and have taken over much of the paperwork. Some of the members started to plan World Mental health Day events for October 2008. All members are given an evaluation form every year to complete and return.
- All users who engage with advocacy are actively involved in the decision-making process. The very nature of advocacy demands a proactive, user-led service; driven by the issue and instructed by the user.
- Our service recruits, trains and supervises volunteers who run the Patient's Council in all acute wards

in the north of the county to pick up the general in-patient ward issues by meeting with patients on the wards on a monthly basis.

- The nature of advocacy involves the service user every step of the way and there is an evaluation based on anonymous postal questionnaires carried out annually. Questionnaires are returned to the service manager for collating. However there are issues around the effectiveness of this. An example of this is a client I carried out a considerable amount of work who told me “thank you for all the work you have done but I could not be bothered to fill in the feedback form”.
- I often take forward group advocacy concerns from regular attendees at the community venues (day services) such as requests for certain activities (evening events, music making) or particular kinds of support (home visits, more and different relaxation sessions) or things that they would prefer to be different (ways to raise concerns about other service users, use of rooms etc.). I also wonder how well other groups at the Bedale for example are able to raise issues about the way their support is delivered or any other aspect. Despite offering to be available at some of these groups the professionals who ran them basically said that if clients had any need for an advocate she would contact me and really refused to enter into a discussion about facilitating feedback through advocacy about changes they may want to request or other concerns they may have.
- I was involved in one part of a consultation that the Richmond Fellowship undertook with their volunteers and service users about how to improve and make their services more responsive.
- By contrast a lot of the advocacy I have provided is to help clients be more involved in discussions about their treatment and medication in the statutory services.
- With some clients, although I have carried out a huge amount of work with them involving exploring all the issues, challenging and appealing all decisions the outcome is still not what they had anticipated and therefore I may receive constructive feedback on this basis.

### **Complaints/Accidents**

- There seems to be a common theme running through certain client complaints about how they were given different information by many professionals, some of which is conflicting. There are also a number of complaints against psychiatrists who give very prescriptive views.
- This year I have been involved in several cases that have gone from local resolution, health commission and ombudsmen but have been resolved through my mediation with Service managers from the PCT, CMHT's and West Sussex DAAT.
- Complaints by individuals about the lack of time spent seeing Social workers and not having proper reviews of care plans.
- The main complaints issues clients have asked for advocacy intervention with are not feeling properly heard by professionals, not being given opportunities to consider other options in terms of medication or treatment and support options, professionals being inadequately prepared with client history, information and expert knowledge in meetings, professionals not conducting themselves in a professional manner e.g. inadequate or mis-representing details of meetings in written documents, insensitive and impatient responses to clients and in one case asking a client to alter a dosage on a prescription as the wrong amount had been noted.
- Staff and clients have complained that during periods of staff sickness the skeleton service offered has not been acceptable. It seems that the service offered was for urgent enquiries only and some clients and staff complained that they left messages with a brief description of their issues/concerns but did not receive a response.

### **Service Development**

- There is a clear need for a seamless service that does not discriminate against age. I feel that an amalgamation of the existing WAMHS and CAMHS advocacy services with an Older People's service would bridge the gap in services for older people. MIND could be in a position to provide this service if adequate resources such as a further advocate was funded by the PCT or Social Care.
- A significant development for Mind advocacy services should be around the role of IMHA that will be starting in April next year.
- Another development option could be to have separate Advocate's for both inpatient and community respectively. This would enable workers to focus on one service and clients group and provide a more efficient and effective service in the future. An inpatient worker being attached to the hospital could set up a forum for the patients every day rather than twice a week at present, reassuring patients that a worker would be able to support them with their issues on a daily basis.

- I have continued to network widely, and was asked to make a presentation to Sussex Midwives in Crawley. Some of the mums they work with are young people, and workers felt the advocacy project would be useful.
- I also feel a counselling service for adults with Mental Health Problems would bridge the gap in waiting lists for psychotherapy or graduate workers attached to primary sector G.P surgeries.
- To set up a User involvement Co-ordinator in West Sussex to enable service users to fully participate in decisions that affect their individual lives.
- I still feel an Appropriate Adult service would fit well alongside advocacy. I also wonder if there may be Home Office money that could be applied for to set up an AA service.
- To be able to work more co-operatively with the professionals and teams in the statutory services in order to be able to offer clients opportunities to raise issues safely which may improve these services and help in individual's recovery process.
- To publicise and hold perhaps quarterly group consultation forums for any clients to attend and contribute too and then raise these as service user issues with the managers of the CMHTs.
- To link with other community services in some of the geographical areas that are more isolated and have less local support opportunities as I am aware that clients in these areas often struggle to access advocacy and other community services.
- Ward Manager has identified a need for nursing staff to be more informed about advocacy issues including Appropriate Adult work NOT appropriate for ward staff to do. I have offered to be involved in this if they wish as I feel it is important for patients to have legal advice when dealing with police issues and I suspect this may not be happening when an advocate is not involved.
- An awareness campaign, or something similar, of the potential efficacy of advocacy earmarked for the Asian community in Crawley, especially in relation to the important development of Langley Green Hospital, which is located in the most significant population of Asian families in Crawley.
- To develop the role of advocacy to extend to other support groups ie. domestic violence. Also a substance misuse/alcohol advocacy service.
- More time dedicated to legal/court advocacy work.